MINUTES

Access to Mental Health Services
2018 Interim Study Committee

Senator Deb Soholt, Chair
Representative Herman Otten, Vice Chair

SOUTH DAKOTA LEGISLATURE
LEGISLATIVE RESEARCH COUNCIL

Second Meeting, 2018 Interim

Tuesday, August 07, 2018

Avera Behavioral Health Center
4400 W. 69th St., UPA Classroom 1583
Sioux Falls, South Dakota

The second meeting of the Access to Mental Health Services (AMHS) 2018 Interim Study Committee was called to order by Senator Deb Soholt (Chair) at 9:20 a.m. CDT, on August 7, 2018, in UPA Classroom 1583 of the Avera Behavioral Health Center located at 4400 W. 69th Street in Sioux Falls, South Dakota.

A quorum was determined with the following members answering the roll call: Senators Craig Kennedy, Kris Langer, Deb Soholt (Chair), Alan Solano, and Jim Stalzer; and Representatives Michael Diedrich, Steven Haugaard, Taffy Howard, Jean Hunhoff, Kevin Jensen, Tim Johns, Herman Otten (Vice Chair), Tim Reed, and Susan Wismer. Senator Bob Ewing was excused.

Staff members present were Emily Kerr, Legislative Attorney; Wenzel Cummings, Senior Legislative Attorney; and Jason Simmons, Principal Fiscal and Program Analyst.

NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council office. This meeting was webcast live. The archived webcast is available at the LRC website at sdlegislature.gov.

Approval of Minutes

A motion was made by Senator Langer, seconded by Senator Stalzer, to approve the minutes of the Access to Mental Health Services Study Committee meeting held on June 28, 2018. Motion prevailed on a voice vote.

Opening Remarks

Senator Deb Soholt, Chair, thanked the committee members and the members of the public for attending and provided an overview of the speakers on the agenda. Senator Soholt highlighted the publication "The Legislative Primer Series on Front End Justice: Mental Health" (Document 1) available on the National Conference of State Legislatures website and its link to the presentation by law enforcement later in the day. On Monday, August 6, 2018, the committee toured Lewis and Clark Behavioral Health Services, Inc. (LCBHS), a community based mental health center in Yankton, South Dakota, providing services including substance abuse treatment, and Dr. Thomas Stanage, LCBHS Executive Director, gave a presentation with members of his staff (Document 2, Document 3). Next, the committee toured the Human Services Center and listened to presentations from the new Administrator of the Human Services Center (HSC), Ken Cole, (Document 4), and Amy Iversen-Pollreisz, Deputy Secretary of the Department of Social Services (Document 5, Document 6, Document 7, Document 8, Document 9, and Document 10).

National Mental Health Trends

Ms. April Hendrickson, Western Interstate Commission for Higher Education (WICHE), provided a national perspective on ways to increase provider competencies through practice and training and shared South Dakota's requirements for community mental health center staff and independent providers. She emphasized the need for maximizing workforce capacity. Next, Ms. Hendrickson spoke on using outcome data and fidelity to evaluate programs, including aggression replacement training (ART), functional family therapy (FFT), and systems of care (SOC). She pointed out that the higher fidelity to a model the greater the likelihood of achieving expected outcomes. Ms. Hendrickson demonstrated the indication of trends and their impact on the criminal justice system. South Dakota is currently implementing ACT, MRT, and FFT as evidence based practices, and Ms. Hendrickson described the evidence based practices implementation cycle, noting that it is not time to start looking at outcomes until in full implementation or sustainability phases. She provided statistics on children with a serious emotional disturbance (SED) that end up as adults with serious mental illness (SMI) and provided handouts with additional information (Document 11, Document 12, and Document 13).

Senator Soholt urged committee members to pay attention to fidelity to determine if a program is something the legislature should invest in.

Senator Alan Solano added that during the 2018 Legislative Session, the legislature funded a pilot mental health court in Rapid City, which will begin in early 2019 with a small number of cases.

Law Enforcement and Judicial Continuum of Mental Health

Chief of Police Matt Burns, Sioux Falls Police Department, described his department's attention to suicides and mental health and explained the pilot program crisis intervention team and the mobile crisis team (MCT) model. This program has not only lowered the number of involuntary commitments but also raised quality of care, and there is interest in the model across the state. It helps individuals stay on treatment regimens and in contact with their providers, which is of great help to law enforcement. An upset to regimen, schedule, or medication often precedes an individual coming into contact with law enforcement in a mental health crisis situation.

Mr. Jeff Gromer, Warden, Minnehaha County Jail, shared that the mobile crisis team diverts many individuals who were previously coming to jail. The jail is left with people who mobile crisis didn't reach or individuals experiencing a severe episode. He also described issues with individuals using illicit drugs. Jails are not designed as therapeutic mental health environments. He also discussed efforts for suicide prevention and the process to stabilize and detox from illicit drugs. The jail's primary focus is on acute stabilization upon entry. Mental health care is provided for individuals with longer stays in the county jail, including individuals awaiting trial, assessment, or competency to stand trial. Jail employees often see substance abuse in conjunction with no stable medication routine. The jail usually has 400-450 inmates at a given time and has around 20,000 inmates total during the year. In the last six months, approximately 3,700 individuals were screened and 13.5 – 14% of these individuals warranted a mental health services assessment. A substantial number of individuals need to be connected to mental health services on the way out of jail, and Warden Gromer described the work of the county alliance team and mental health professionals for these individuals.

Senator Soholt asked if the jail was seeing a trajectory of individuals to the HSC and where are the gaps. Warden Gromer answered that for emergency commitments, the jail works closely with the Minnehaha County Board of Mental Illness. Providers see inmates at the jail when inmates present a danger to other patients or staff. In an emergency commitment, if the individual is not charged with a criminal charge, the individual is only housed for 24 hours in jail. Cases are highly individual, and the jail sometimes sees behaviors beyond what a hospital can safely accommodate, creating a short term but complicated issue.

Senator Soholt inquired as to the emergence of a mental health triage center concept. Warden Gromer answered it is an alternative to get individuals into the health care system without using high intensity resources, such as emergency medical services, jail, or a board of mental illness. This would target frequent fliers in the county system. The county is looking at where to route to avoid high dollar, high intensity services. Many individuals don't need the high intensity services but rather a warm hand off to more appropriate services. This concept is still in planning discussions, including the level of medical care and security needed. The intention is to provide an intermediate level of care and an option to route the individual somewhere other than jail or involuntary commitment.

Mr. Aaron McGowan, Minnehaha County State's Attorney, reminded committee members that there is always a gap in county resources. He described a murder defendant waiting for a bed at HSC for two months when the defendant was judged incompetent to stand trial. He described the frequency of co-occurring disorders with substance abuse and the 30% increase in meth-related arrests in Minnehaha County, which totaled around 1,500 in the county in 2017. He estimates that 80-90% of serious offenses are chemically propelled, including property crimes, and he cited the prevalence of individuals self-medicating with alcohol, prescription drugs, or illicit drugs. Methamphetamine arrests are leading to long-term contact with the criminal justice system, creating a revolving door effect. He urged the committee to concentrate on prevention, including mental health components, and Mr. McGowan is supportive of the triage concept to save tax dollars and keep people out of the criminal justice system. He raised the issue of ordering individuals to stay compliant with their medication regimen to prevent severe episodes and the need for oversight to ensure compliance. He said South Dakota cannot continue at the current trajectory. Mr. Gowan pointed out the overlap with the criminal justice and health care systems, especially individuals overusing emergency rooms.

Sergeant Tarah Walton, Sioux Falls Police Department, Crisis Intervention Team (CIT) Coordinator, teaches the CIT class for law enforcement officers, dispatchers, parole agents, firefighters, and others (Document 14). State statute only requires the course for new law enforcement officers. Sergeant Walton explained that CIT is not just about law enforcement officers. The state has paid for a CIT coordinator at the statewide level for one year.

Representative Reed asked what new recruits are taught at the law enforcement training center and if there is an advantage to training at this time versus after more experience. Sergeant Walton answered that the recruits go through an abbreviated version and that when to train is a heavily debated topic. The Memphis Model states that not everyone has that particular skill set and should be trained in CIT. Sergeant Walton believes something similar without certification could be beneficial to everyone. Senator Solano said that the statewide coordinator position is in the process of being filled and that the state is working with Minnesota on developing an eight hour increment of broad based, online CIT, but to be fully

certified would still require in person interaction. Rapid City uses actors to simulate interactions with persons with mental illness.

Representative Hunhoff inquired as to working with tribal law enforcement on this program. Sergeant Walton answered that notifications were sent out statewide. No tribal law enforcement have taken the training but federal agents have participated.

Representative Otten asked if they were working with local small community departments in the area. Sergeant Walton replied that Tea, Minnehaha County, Lincoln County, and Beresford officers have participated.

Senator Solano raised the challenge of departments with small staff numbers and Sergeant Walton said they recognize officers from smaller communities have different needs and try to tailor as much as possible to running specific individual scenarios while adhering to model and mandatory topics.

Senator Soholt asked if an officer in the field could contact another CIT officer for assistance. Sergeant Walton replied that they would rather see the officer contact a mental health professional.

Ms. Kim Hansen, IMPACT, Homeless & Mobile Crisis Program Coordinator, Southeastern Behavioral Healthcare, Sioux Falls, presented on the Mobile Crisis Team (MCT) in Sioux Falls (Document 15). Team members work with the individual in crisis to develop a safety plan and recommend follow up services, including case management. The average time per call for the MCT in Sioux Falls is one hour. The law enforcement officer provides the satisfaction rating afterward when the mobile crisis team reports to the scene.

Senator Solano asked if this could be opened up so that anyone (families) could call without law enforcement involved. Ms. Hansen answered that it was discussed but at this time the team wants law enforcement involved for safety.

Senator Soholt asked if Rapid City has a fixed place for this situation. Senator Solano replied Rapid City is focused on 23 beds observation capacity for holding individuals for 8-9 hours in crisis. The intent is to divert from the emergency department. The vast majority of referrals in Rapid City are from individuals or families, rather than limiting referrals to law enforcement.

Senator Soholt asked if Pierre is developing a team. Ms. Hansen said they have answered questions for Pierre but have not assisted in developing a team.

Representative Hunhoff inquired as to the process for restoring competency for individuals declared incompetent to stand trial. Mr. McGowan replied there have been some changes but the issue is waiting months for this type of bed to be available at HSC. Warden Gromer replied that they see that competency deteriorates again when the individual returns to jail. Individuals would rather be at HSC and the jails see medication refusals and acting out by the individuals. A mental health provider at the jail will monitor and adjust medication and monitor the process until the inmate is restored to competency.

Senator Soholt said that legislation now requires people in jail to take mental health medications. Warden Gromer answered that the statutory changes to resolve HIPAA and privacy issues in continuum of care information are working very well.

Representative Wismer asked about the numerous evaluations but still a lack of available beds. Warden Gromer replied that this is a specific situation for individuals declared incompetent to stand trial, but he believes this type of housing is currently full at HSC.

Mr. James L. "Jim" Iosty, Chair, Minnehaha County Board of Mental Illness, said that Minnehaha County went from around 1,800 to 1,300 cases after mobile crisis team. He described the board process and stated that SDCL chapter 27A-10 on "emergency commitment" requires a hearing within five days. The hearing is a balancing of many important rights. In our state, very few people can put a person on a hold. Only a law enforcement officer in South Dakota may make the designation without an order by a judge or board of mental illness. Minnehaha County has six designated qualified mental health professionals to evaluate individuals. A county has to pay for the expenses of those placed on a hold by their board.
Mr. Iosty looks for who will take care of or support an individual if they are released. In 2017, Minnehaha County had 140 commitment hearings, which is almost ten times more than previously and the county is on track to beat that number in 2018. Lincoln County has changed dramatically with over 600 cases per year. Counties need more revenue to deal with these growing problems. Many repeat individuals have stopped treatment or medication. Mobile crisis and law enforcement do a tremendous job weeding out momentary crisis cases.

Ms. Brenda Ask, Chair, Lincoln County Board of Mental Illness, shared the issues Lincoln County faces with the high volume of cases for its board of mental illness. She stated there is no longer an interstate compact, so they are continuing to treat out of state residents. Lincoln County is stuck with nonresident bills because individuals are not able to get into HSC. She raised the possibility of the state rather than Lincoln County paying these nonresident expenses. Counties only get expenses if findings are entered as to residency, but findings are only entered when a hearing occurs. Expenses incurred before hearings take place, and many filings never lead to a petition. Ms. Ask called for residency findings based on petition. She also raised the issue of transfers from other counties and the need to change statutes from referring county to the county initiating the petition and hold. Not all counties have a safe place to hold individuals for the first 24 hours. Counties are incurring costs to transport patients to Lincoln County and back to be held. There are also open court files not getting confidentiality and seal of dismissal (Document 16).

Representative Haugaard described the process and issues with boards of mental illness and the utilization of qualified mental health professionals. Boards of mental illness determine: jurisdiction, residency, is there mental illness, does the individual present a danger to themselves or others, and if there is a benefit to treatment services. If the board finds some degree of benefit, it orders treatment, or, alternatively, orders release. He emphasized the need for more staff and resources and to revise the statutes on involuntary commitment.

Senator Soholt asked why there are only so many functioning boards. Ms. Ask and Mr. Iosty offered a variety of reasons as to why counties handle the process differently.

Representative Wismer inquired how Lincoln County would reduce individual expenses. Ms. Ask stated the challenge is the requirement to drop the hold when it is no longer needed. Lincoln County does not evaluate daily like Minnehaha County. Representative Wismer followed up by asking if other states have this payment organization and structure. Mr. Iosty replied that South Dakota and Nebraska use the county board system and that other states use court rooms and have different hold time frames. Ms. Ask replied that some states have statutes that allow a judge or magistrate judge to be contracted and that maybe a potential solution is for the state to pay for a magistrate judge.

Senator Solano emphasized that statutes in this area are removing and restoring an individual's civil rights. He also stated there is a need for more crisis intervention. Senator Soholt responded that Minnehaha County is looking for place to hold individuals while the issue is being determined and assessed. Ms. Ask said that her county is seeing many cases of drug induced psychosis and the need for these individuals to detox rather than take up commitment treatment beds.

Representative Otten asked if the county is doing follow up. Ms. Ask answered the statute states the county where patient is held has that control and it is basically an administrative decision.

Senator Craig Kennedy asked if hearings in Yankton have witnesses available to testify and if second evaluations are completed. Mr. Iosty responded that when an individual has a hold continued past 24 hours, HSC doctors have the authority to release the patient. Other medical providers have the power to release with advice and consent of the county board of mental illness (board). Avera wants board involvement before release to ensure follow up care. The duty of the board chair is to ensure the individual meets criteria each day to continue the hold.

Community Mental Health Support

Ms. Wendy Giebink, Executive Director, National Alliance on Mental Illness (NAMI) South Dakota, Sioux Falls, stressed the importance of sharing best practices with others and described the work NAMI SD does with middle school and high school programs. Youth typically do not have the types of information they need to identify issues and seek help. When NAMI presents in schools, youth often say this is the first time they are hearing real information on mental health conditions. Ms. Giebink discussed the number of individuals who sign up and who have completed a program with NAMI. Transition care and long term care is frequently brought up in the organization's work, along with the reality that there is not enough access to mental health care in communities. NAMI SD is continually asked for mobile crisis type services in communities. Ms. Giebink is frequently requested to talk about and advocate for mental health boards. She described the revolving door that loved ones experience and the lack of an adequate safety net, and she called for more education for school staff, parents, and students. Ms. Giebink shared with the committee that early intervention works and that her organization is trying to reach every student in South Dakota, which is a difficult task as a volunteer organization. She is worried about increased mental health diagnoses in children (Document 17, Document 18).

Senator Alan Solano asked if NAMI SD utilizes peer support specialists. Ms. Giebink replied that South Dakota does not have laws in place for peer support specialist requirements or training. A peer support specialist is a trained individual that engages in assistance tasks, such as giving rides, providing discussion support for the patient, and assistance with daily activities. Currently, there is not a way to bill for this, so

there is subsequently a lack of provider interest in making this happen. The Veterans Administration has a version of this type of support role. Senator Solano followed up by asking if NAMI has national peer support training and credentialing. Ms. Giebink answered because of the reasons she stated earlier this is not something NAMI SD has pursued but the state organization offers peer-to-peer training.

Ms. Janet Kittams, President, Helpline Center, Sioux Falls, described the work and offerings provided by the Helpline Center. The suicide crisis line is a national number and is routed to the closest certified crisis line. Helpline Center is the only certified crisis line in South Dakota. 211 was set aside by the federal government for health and human services usage. The Helpline Center provides listening and support to callers in need and access to resources, and the center also offers services via text and web. Ms. Kittams stated it is a collaborative project to integrate social services in Sioux Falls. Unfortunately, 211 is not available statewide and is available to only 65% of state population. The Helpline Center is trying to identify sustainable funding sources to expand 211 statewide. The highest majority of calls are Level 1, and the volume of these calls has been increasing significantly. She is glad that the level of awareness isrising and that people are contacting the Helpline Center at the front end. She described a "did not intervene" situation as one where 211 was able to deescalate the crisis, develop a safety plan, and the caller felt they were safe now and did not have to contact or involve law enforcement. Wellness checks involve law enforcement or a mobile crisis team. A small amount of calls result in a collaborative rescue where an individual knows they need help, and together 211 and the individual voluntarily collaborate in seeking help. Occasionally the organization must make a police report, i.e., need to report child abuse to law enforcement. The Helpline Center is at the forefront of responding to mental health crisis. Ms. Kittams pointed out that many private practitioners also offer telehealth.

In three communities, the center publishes mental health resource guide books, partnering with local resources for funding and to publish online. Individuals are accessing the Helpline Center's online database on a regular basis. 211 has its own internal database to use when helping individuals and help sheets that 211 workers can text, email, or offer online for more information on specific topics, e.g., Considering Counseling, How to Help a Loved One in a mental health crisis. The Helpline Center is part of a federal SAMHSA grant to partner with the four psychiatric hospitals to do follow up. Patients are offered the opportunity to participate in the follow up program. Within 24 hours of discharge, 211 contacts the patients and provides support, suicide risk assessment, depression screening, barriers to getting to appointments. (Document 19)

Senator Jim Stalzer asked what the financial need would be to expand 211 statewide. Ms. Kittams responded that when a bill was drafted several years ago, the cost was around $300,000. Senator Stalzer followed up by asking if calls have increased now with the suicide epidemic. Ms. Kittams replied that when 211 is new to a community, individuals call 211 for everything, including suicide crisis.

Senator Deb Soholt pointed out that for reporting issues such as potential cases of child sexual abuse, there are multiple statewide numbers which confuses individuals. 211 is a way to push people to the right location and resources and that it is much easier to remember 211 than a "1-800 number."

Faith-Based Mental Health Support

Dr. Marcie Moran, Clinical Director, Catholic Family Services, Sioux Falls, is known in South Dakota for setting benchmark practices for working with families in crisis. Catholic Family Services (CFS) has four full time employees and ten other licensed practitioners in eastern South Dakota with a centralized billing and scheduling arrangement. CFS has a therapist helper online to share records and talk with outreach providers and grief counseling services. CFS held the first children's grief camp, which was quickly filled to capacity. CFS has psychiatrists on its board but not on their staff. All CFS counselors are licensed professionals. CFS does not host support groups, but sees approximately 650-700 clients per year. Its grief center is funded primarily through donations, and CFS generally receive clients through word of mouth from parishes and past clients. CFS also receives grants, and its back up funding is additional Catholic family sharing monies from the church. However, the organization tries to operate independently.

Senator Soholt asked if Dr. Moran sees linkages from the criminal justice system or chemical dependency. Dr. Moran replied that the service is more community based but has trained jail staff on suicide prevention. The service will go into workplaces or schools that have experienced violence and has a different focus than law enforcement crisis team. CFS helps the people traumatized by the act.

Representative Jean Hunhoff asked if CFS has state contracts. Dr. Moran replied that they receive Victims of Crime Act (VOCA) funding. Representative Hunhoff followed up by asking if they accept Medicaid. Dr. Moran replied that CFS has contracts with a variety of payers and treats all faiths, ages, cultures, and people who travel from a distance. CFS has a fund open for donations. Dr. Moran stated that CFS probably does more prevention (deescalation) than treatment.

Mr. Thomas Otten, Assistant Vice President, Avera Behavioral Health Services, Sioux Falls, provided an overview of the services provided through Avera Behavioral Health. One of the organization's biggest struggles is that Medicaid does not cover partial hospitalizations. Strong relationships are important in South Dakota. He stated that Avera should be utilized for shorter term stays and HSC for longer hospitalizations. (Document 20).

Representative Jean Hunhoff asked why Avera hospitalizations are shorter compared to HSC. Mr. Otten replied it is because of different patient populations. HSC has psychiatric rehabilitation, nursing home patients, and longer term forensic patients. 15-20% of Avera's hospitalizations are for 24 hour holds for South Dakota patients, while pointing out that Minnesota is 72 hours and Iowa is 48 hours. Representative Hunhoff followed up by asking if other payers pay for partial hospitalizations. Mr. Otten replied virtually every other third party payer does. Representative Hunhoff followed up again asking if Avera has behavioral health homes. Mr. Otten said that they do within their medical homes but do not have behavioral health specific health homes.

Senator Deb Soholt inquired as to the capacity for more short-term holds at Avera than at HSC and asked if many patients could benefit from partial holds. Mr. Otten replied that Avera does have more capacity, either as substitute for inpatient hospitalization or for follow up care.

Representative Haugaard asked what is the partial program cost per day. Mr. Otten replied it is around $220 per day for around 17 days.

Ms. Betty Oldenkamp, President and CEO, and Ms. Rebecca Kiesow-Knudsen, Vice President of Community Services, Lutheran Social Services of South Dakota (LSSSD), Sioux Falls, shared that counseling services is one of longest operating programs at LSSSD, beginning in the 1980s. This program does not have an operating surplus, so LSSSD has to do additional funding. LSSSD offers counseling services on a sliding fee scale to patients and also provides services through the Juvenile Justice Reinvestment Initiative (JJRI) and the Criminal Justice Initiative (CJI). LSSSD faces maintaining a focus on rural communities while keeping its budget in line. The counseling service program utilizes telehealth and is now working with PATH – Sioux Empire United Way – for a school based setting for mental health services. The organization struggles with recruiting staff in the northeast part of the state. Medicaid billing forces LSSSD to recruit providers at the highest levels of practice. LSSSD pay is not at the top of the field and it is difficult to offer competitive salaries and to keep positions filled. The organization offers a related service line, providing re-entry services in its new Intermediate Correctional Invention Program (ICIP), a nine month community based prevention program for female reoffenders. Approximately 47% of the counseling service revenue comes from the Medicaid population. (Document 21).

Senator Alan Solano asked about participation in the ARISE program for low-level youth offenders.
Ms. Oldenkamp answered that JJRI entered into partnership with Pennington County and later Minnehaha County for ARISE youth for services from a youth individual's first point of contact with law enforcement. Senator Solano asked if there is a need for secure detention or if the youth can be released home. The program is diverting around 300-400 youth per year out of detention in Pennington County and refers youth to other services to keep youth from progressing deeper into the criminal justice system.

Senator Kris Langer asked if there is a rise in girls ages nine to fourteen facing suicide and getting into trouble. Ms. Oldenkamp would not perceive this as a new issue, and LSSSD has been serving these females for some time, including facing trauma and self-harm. These girls tend to internalize more while boys externalize more. Some cases involve psychiatric residential treatment.

Public Testimony

Ms. Staci Ackerman, Executive Director, South Dakota Sheriffs' Association, called for options other than involuntary commitment and 24 hour holds. Jails would prefer not to hold individuals in mental health crisis if a crime is not involved. Sheriffs are working to bring the Memphis Model to the state as a combination of 24 hours of online training (including at least one hour of South Dakota specific law and procedures) and in person training. Rural law enforcement are often ahead of the curve because they personally know individuals, families, and providers. Mobile crisis teams would be ideal statewide but bring many challenges for rural areas. Ackerman spoke about her organization's involvement in implementing the jail mental health screening tool. She said the next step is to identify what services are available to access in communities. Sheriffs receive calls for service for individuals with severe dementia or autism because their families feel unsafe. There is a great need for places to take these individuals.

Committee Discussion

Senator Jim Stalzer called for the need to fund 211 services throughout state.

Senator Alan Solano asked for research on commitment laws as relating to dementia, including states that allow commitment strictly on dementia. He called for population based data, including acute population beds based on per 100,000 for West River as well as the northeast.

Representative Taffy Howard expressed interest in digging more into workforce issues to examine the shortage of qualified workers in the field and if there are pay or training issues. She shared her concerns with co-occurring mental health and substance abuse issues.

Representative Tim Reed called for understanding capacity in different areas, i.e. what are wait times, queues, and how community based mental health centers and others calculate waiting list times. He also inquired as to what West River needs for placement and the resources it costs to send someone to HSC from long distances.

Representative Susan Wismer lamented the lack of payer resources for voluntary treatment. She also emphasized county mental health board issues and asked why South Dakota and Nebraska operate this way versus other states with a statewide or court based system.

Representative Kevin Jensen said the state still has a rural access problem and that sometimes, the first contact in a rural area can be law enforcement. He called for using local clinics and providers for initial screenings.

Representative Steven Haugaard stated telehealth is not easily billable and emphasized the need for more teleservices throughout the state. He wanted to explore early intervention and Dr. Moran's focus on prevention more than treatment. He called for engaging community services and churches. Representative Haugaard expressed interest in looking at the costs and effectiveness of reopening closed units at HSC and for better ways to handle transport and treatment in underserved areas of the state.

Representative Timothy Johns expressed interest in school based mental health, early identification, and early intervention, along with workforce shortages due to inadequate salaries.

Senator Craig Kennedy asked the committee to consider what the state's role is in providing mental health services in South Dakota. What can or should we do versus what outside (private) entities should do? Can the state handle it on its own or what should we pay others to do?

Representative Herman Otten raised concerns with seeing suicide issues affecting children.

Representative Jean Hunhoff inquired as to the ability of private providers being able to access Medicaid, especially as to what credentials and other requirements are needed. She emphasized the need for promoting independent living and transitional housing.

Representative Michael Diedrich stated that it is clear community-based diversion has been effective and that the special courts look promising. He expressed concern with the inability to bill for licensed professional counselors and masters level social workers in certain instances. He emphasized giving providers the ability to offer services at the top of their licensure.

Senator Kris Langer expressed concern with the aging population of psychiatrists in the state and the lack of for dementia and aging patients, as nursing homes are hesitant to accept patients in need of higher levels of mental health care.

Senator Deb Soholt asked the committee to consider what it would be like not having nursing home patients at HSC and what kind of supports (virtual, etc.) would be needed to make this happen. She called for considering regulatory review issues and paying for partial hospitalizations to open up bottlenecks. Senator Soholt inquired as to the possibility of using triage assessment centers to deescalate crisis.

Final Remarks and Next Steps

Senator Soholt stated the next steps are for the committee to begin to assimilate the information presented in the last two meetings to paint a picture of access to mental health services in South Dakota, including appropriated budgets, grant dollars, and determining best practices. Senator Soholt tasked the committee with contemplating the long-term trajectory of the issue.

Next Meeting

The next meeting of the Access to Mental Health Services Study Committee will be held in Pierre on September 11, 2018. Additional meetings for the study committee are scheduled for Wednesday, October 17, 2018, and Monday, November 19, 2018, also to be held at the State Capitol in Pierre, South Dakota.

Adjourn

A motion was made by Senator Langer, seconded by Representative Reed, that the Access to Mental Health Services Interim Study Committee be adjourned. The motion prevailed unanimously on a voice vote.

Chair Soholt adjourned the meeting at 3:28 p.m.